Medi-Cal Pararegs

400-1 Medi-Cal regulations are in Title 22, California Code of Regulations (CCR), and cites are to the CCR (50005)
400-1A W&IC is the abbreviation for the Welfare & Institutions Code
400-2 Reference to DSS regulations on hearing procedures (50953)
400-3 DHS has sole authority for Medi-Cal decisions (50953(c))
400-4 Rehearing time limits (50953(c)(2))
400-5 Medi-Cal Program administration (50004)
400-6 Federal rules at Medicaid hearings (42 CFR 431.242)
400-7 Federal rules regarding hearing decisions (42 CFR 431.244)
400-8 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))
401-1 After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)
404-1 Requirements for denial NOA (ACWDL 97-48)
404-2 Required language on NOAs denying due to excess property (ACWDL 97-41)
404-3 Required county actions, and required NOA language, after approval of retroactive Principe benefits (ACWDL 97-41)
404-4 When an NOA must be sent in regard to "medical services" (51014.1(a))
404-4A Contents of the required NOA for reduction or termination of "medical services" (51014.1(c), (i))
404-4B APP requirements when there is a timely filing after proposed reduction or termination of "medical services" (51014.2(a), (b))
404-5 NOA requirements when a CalWORKs discontinuance occurs 7/1/01 and following (ACWDL 01-17; SB 87)
404-6 BICs have replaced Medi-Cal cards and MC 177 forms as of 6/1/97; NOA is required before discontinuance can occur (ACWDL 96-06; Denti-Cal Bulletin, Vol. 13, No. 13; *Bowman* v. *Belshé*)

410-1 Time period for processing applications; reasons for extension of such limits (50177(a))
410-1A County must refer disability application to DED within 10 days (ACWDL 93-50; *Radcliffe* v. *Cahill*)
410-1C After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)
410-2 Circumstances under which persons other than applicant or spouse may complete application documents (50163(a))
410-2A Definition of "applicant" (50021)
410-2B Definition of "competent" (50032)

410-2C Application defined; county duty to complete SAWS I when applicant calls in to apply for Medi-Cal (50022; ACWDL 00-31)
410-2D Medi-Cal form 210 available in English and 10 other languages (ACWDL 01-68)
410-3 Face-to-face interview necessary only at time of application and not required when adding adults to MFBU; totally eliminated effective July 1, 2000 (50157(a); ACWDL 99-36, 00-17, 00-31)
410-3A Elimination of face-to-face interview except when good cause or fraud exist (ACWDL 00-31)
410-3B Beneficiary is a person determined eligible for Medi-Cal (50024)
410-4 Procedure for withdrawal of Medi-Cal application (50155)
410-5 Persons who may file an application (50143(a))
410-6 County duty to accept and promptly act on applications; who may file applications (50141, 50143)
410-7 Application as a basis for determination, applicant's duty to provide necessary additional information; county's duty to assist in this process (50171)
410-8 County welfare department the agent of CDHS (50004(c))
410-9 Requirements to protect applicants' right to apply when welfare offices closed on normal working days (*Blanco* v. *Anderson and Belshé*)
410-9A Requirement to provide for filing applications on normal working days implemented (Blanco v. Anderson; ACL 94-108, 95-08)
410-10 Medi-Cal must continue for beneficiaries discontinued from Title II or SSI at least for 65 days, and if appeal is filed and is subject to federal review, until "FINAL" decision (i.e., no more appeals can be filed) is rendered (ACWDL 97-28)
410-11 SSI former recipients are PA recipients until appeal rights are terminated, even if they transfer to AFDC/TANF and then are discontinued from AFDC/TANF (ACWDL 97-28)
410-12 No longer disabled SSI/SSP recipients to be treated akin to *Edwards* discontinuances (ACWDL 97-28)
410-13 County of responsibility when eligibility is not based on being part of a family or on family income (50125)
410-13A County which accepts application, but is not county of responsibility, may still process application with consent of applicant, and initiate ICT (50135)
410-14 Requirement to outstation EWs at Disproportionate Share Hospitals and Federally Qualified Health Centers (ACWDL 98-13)
410-15 Required county actions, and required NOA language, after approval of retroactive Principe benefits (ACWDL 97-41)
410-16 Notice to be sent when re-evaluation of Medi-Cal eligibility occurs (W&IC 14005.31(b))
410-17 What happens when Medi-Cal benefits are transferred from one program to another, and required notice (W&IC 14005.32(a))
410-17A Written TMC notice must be given to CalWORKs and 1931(b) recipients when Medi-Cal eligibility is determined and six months thereafter, or when they are terminated due to failure to meet reporting responsibilities (ACWDL 01-45)

410-18 When re-evaluation shall not re-occur after loss of Medi-Cal eligibility; continuation of benefits when evaluation is occurring; required notices (W&IC 14005.37)

410-18A County requirements after denying or discontinuing CalWORKs/1931(b) benefits, including ex parte responsibilities (ACWDL 01-36)

410-18B Specific mandate to use Form MC 355 as request for information form, contents of the form, time limits, county requirements (ACWDL 01-39)

410-18C Required SB 87 procedures for counties evaluating Medi-Cal eligibility (ACWDL 02-59)

410-18E County must reevaluate eligibility under other Medi-Cal categories if eligibility ceases under one category; aid pending continues, effective 7/1/01 (50183(a); MEPM 4-0-3; W&IC 14005.31, .32, .37; ACWDL 02-59)

410-18F Medi-Cal beneficiary may continue to receive Medi-Cal after SSI/SSP discontinuance based on "no longer disabled" if he/she alleges a new disability (ACWDL 04-31)

410-18G Steps county must follow in different circumstances regarding annual redetermination form (ACWDL 06-16)

410-18H County must follow SB 87 process if annual redetermination packet is returned as undeliverable (ACWDL 06-16)

410-19 If county is sure that there is no need to transfer eligibility to another Medi-Cal program, no redetermination necessary but documentation must occur and notice must be sent (W&IC 14005.39)

411-1 Purpose of Medi-Cal Program is to provide, to the extent practicable, health care benefits to eligible persons (W&IC 14000)

411-2 County must act with courtesy, consideration, and respect (W&IC 10500)

413-4 Medi-Cal form 210 available in English and 10 other languages (ACWDL 01-68)

414-1 Duties of counties which have a procedure for screening applicants (50142)

414-2 IHSS and AFDC applicants not required to submit separate application. If AFDC or IHSS is approved, Medi-Cal is automatic (50145)

414-3 Persons or families denied Medi-Cal under any program other than SSI/SSP shall be reviewed for any other type of eligibility (50180)

414-4 County shall set reasonable deadline for returning the Statement of Facts, inform applicant of the deadline, and attempt to contact applicant if Statement is not submitted by deadline (50165)

414-4A Requirements for two contacts, then specific NOA, if county is to deny applications for failure to provide information; discontinuance actions governed by SB 87 (ACWDL 90-07, 97-48, 02-59)

414-5 Legislative intent to process nursing facility applications timely, and to encourage nursing facility participation (SB 635)

414-5A County may not deny application of LTC person due to non-cooperation of representative, but must do diligent search (ACWDL 94-62)

414-6 Nursing facility applicants shall be assisted in applying and have applications processed timely (W&IC 14110.05)

414-7 Requirement to outstation EWs at Disproportionate Share Hospitals and Federally Qualified Health Centers (ACWDL 98-13)

414-8 Two contacts mandated, and must be documented, when county is proposing to discontinue on redetermination and beneficiary fails to provide information/verification (ACWDL 97-48)
414-10 Income maintenance responsibility to make and record eligibility and grant determinations for PA cases, and for MN SOC cases (MPP 11-501.1, .2)
414-11 State law eliminated the requirement that pregnant women and children complete a face-to-face interview (W&IC 14011.1; ACWDL 98-42)
414-11A Elimination of face-to-face interview except when good cause or fraud exist (ACWDL 00-31)
414-12 County must send informing brochures and forms with redetermination notice, and provide such information to beneficiaries on request (ACWDL 99-36)
414-13 Application defined; county duty to complete SAWS I when applicant calls in to apply for Medi-Cal (50022; ACWDL 00-31)
414-13A Protecting the date of application in mail-in or walk-in situations; county duty to assist; when applicant need not sign application for Medi-Cal, but must still sign for CalWORKs and FS (ACWDL 01-06)
414-13B Information which must be included when an application is mailed to, or handed to, an applicant (ACWDL 01-06)
415-1 Denial of application for failure to cooperate (50175(a))
415-1A Parent, not child, disqualified for parent's failure to cooperate with medical support or identifying an absent parent or determining paternity (ACWDL 93-56, 97-64; 50175(a)(7); MEPM 23E-1, 2; W&IC 14008.7)
415-1B Denial/discontinuance for noncooperation applies only to individual who fails to cooperate and those for whom he/she is responsible (ACWDL 92-09)
415-1C Annual Medi-Cal redetermination required by state and federal law (ACWDL 06-16)
415-1D Informing beneficiary of annual redetermination requirements (ACWDL 06-16)
415-1E Counties must mail only MC 210 RV form along with mandated program information; no need for *ex parte* review prior to sending redetermination packet (ACWDL 06-16)
415-1F County must allow beneficiary at least 20 days to complete and return required forms; may not require face-to-face interview unless SB 87 process will not resolve all issues (ACWDL 06-16)
415-2 General duty of applicant or beneficiary to cooperate (50185(a))
415-2A DA decides whether person has cooperated in identifying the absent parent, securing medical support, and determining paternity, but the county makes the good cause determination (ACWDL 97-64; MEPM 23E-1)
415-2B Good cause claim for cooperation re paternity, medical support results in eligibility for Medi-Cal if other conditions are met, and once granted, shall continue until or unless the county decides at redetermination that circumstances have changed (MEPM 23E-1)
415-2C Criteria for establishing if good cause for noncooperation with the FSD/DA exists, and evidence which can support claim; good cause determination made by county (MEPM 23E-2, 3)
415-2D FSD/DA makes determination of noncooperation in establishing paternity, medical support; necessity to have staff persons readily available; cooperation

requirements and factors to consider as to whether cooperation exists (MEPM 23E-1)

415-3 Denial or discontinuance due to noncooperation can be rescinded if good cause established (50175(b)(2))

415-4 Good cause for failure to cooperate (50175(c))

415-4A If good cause for failing to return forms within 30 days after Medi-Cal termination, Medi-Cal is reinstated without break in benefits; if no good cause' beneficiary must reapply (ACWDL 06-16)

415-4B If annual form returned complete with verification within 30 days of termination, county must determine eligibility as though submitted timely (ACWDL 06-16)

415-5 Duty to report changes within 10 days (50185(a)(4))

415-6 Applicant or recipient must take action to accept unconditionally available income as a condition of eligibility (50186)

415-7 Applicant must attempt to obtain Social Security Number (50187)

415-8 Good cause requirements for failure to cooperate in paternity, medical, or child support, or third-party payments (50771.5(a)-(c))

415-9 Serious physical or emotional harm defined; burden on applicant (50771.5(d)-(f))

415-10 Claims for good cause for medical support required only once per situation (ACWDL 93-56)

416-1 Old rule: Status report required at three-month intervals until 1/1/01 (50191; AB 2877; ACWDL 00-64)

416-1A Although status reports no longer required, beneficiary still has duty to report and county still must act on any changes it is aware of (ACWDL 00-64)

416-2 Status reports incomplete if verification is not provided (MEPM 4H)

416-3 Midyear status report requirement and exemptions from that requirement (W&IC 14011.16; ACWDL 03-41)

416-3A Midyear status report filed six months after later of application date or annual redetermination (W&IC 14011.16; ACWDL 03-41)

416-3B County must provide MSR to beneficiary in fifth or "mail"month; MSR must be returned by the fifth day of the sixth or "due" month (W&IC 14011.16; ACWDL 03-41)

416-3C If MSR reflects change in circumstances effecting eligibility, county must do an SB 87 determination (W&IC 14011.16; ACWDL 03-41)

416-3D If MSR is signed, but incomplete, county must do an SB 87 determination (W&IC 14011.16; ACWDL 03-41)

416-3E Recipient failure to return an MSR results in discontinuance of benefits (W&IC 14011.16; ACWDL 03-41)

416-3F If recipient submits an MSR within 30 days of discontinuance, county must evaluate and rescind discontinuance if eligibility exists (W&IC 14011.16; ACWDL 03-41)

417-1 *Edwards* v. *Myers* relating to continuing Medi-Cal following the discontinuance of AFDC-related Medi-Cal; re-evaluation for all programs required as of 7/1/01 (MEPM 4-0; W&IC 14005.31, .32, .37)

417-1A Refugees entitled to Edwards benefits (ACWDL 97-57, 01-36, 01-39; *Edwards* v. *Kizer*; MEPM 24B-11)
417-2A When recipient of Medi-Cal benefits is no longer eligible for benefits, re-evaluation of eligibility must occur (W&IC 14005.31(a))
417-2B Notice to be sent when re-evaluation of Medi-Cal eligibility occurs (W&IC 14005.31(b))
417-2C What happens when Medi-Cal benefits are transferred from one program to another, and required notice (W&IC 14005.32(a))
417-2D When re-evaluation shall not re-occur after loss of Medi-Cal eligibility; continuation of benefits when evaluation is occurring; required notices (W&IC 14005.37)
417-2E If county is sure that there is no need to transfer eligibility to another Medi-Cal program, no redetermination necessary but documentation must occur and notice must be sent (W&IC 14005.39)
417-2F Required SB 87 procedures for counties evaluating Medi-Cal eligibility (ACWDL 02-59)
417-3 Four-month continuing Medi-Cal benefits for AFDC families terminated because of increased child/spousal support (50243; ACWDL 90-32, 90-33, 90-66)
417-5 TMC replaces 9-month continuing eligibility, but regulations not changed; TMC eligibility criteria (50243, 50244; ACWDL 90-32, 90-66, 92-59; MEPM 5B-3)
417-6 TMC eligibility (MEPM 5B-3, 4)
417-6A CalWORKs, 1931(b) and Edwards benefits count towards TMC eligibility period (MEPM 5B-11)
417-6B Receipt of CalWORKs plus 1931(b) in 3 of last 6 months meets TMC eligibility test (MEPM 5B-12)
417-6C TMC requirements (ACWDL 90-66, 90-77, 95-85, 98-43)
417-6E What constitutes "because of" hours of employment or earnings for purposes of potential TMC eligibility (MEPM 5B-6, 7)
417-6D Persons who are not eligible for TMC, even if the family lost CalWORKs or 1931(b) benefits due to increased hours of employment or earned income (MEPM 5B-6)
417-6F Persons receiving TMC are ineligible members of the MFBU of those persons who are not eligible for TMC; the ineligible TMC members may be, e.g., 1931(b) or MI eligible (MEPM 5B-10)
417-7 When TMC may be discontinued after initial six-month period (ACWDL 90-66; MEPM 5B-4, 5))
417-7A Written TMC notice must be given to CalWORKs and 1931(b) recipients when Medi-Cal eligibility is determined and six months thereafter, or when they are terminated due to failure to meet reporting responsibilities (ACWDL 01-45)
417-8 Additional 12 months of TMC after first year for certain 19-year-old and older individuals who continue to meet TMC eligibility requirements (ACWDL 98-56, 01-02; MEPM 5B-5; W&IC 14005.81)
417-8A Second year of TMC eliminated (ACWDL 03-45)

417-9 County should process case for TMC even if flyer returned late (ACWDL 99-20)
417-10 TMC beneficiaries not required to complete annual redetermination (ACWDL 06-16)
417-11 CEC program protects zero SOC children under 19 from discontinuance or an SOC until the next redetermination, or until they turn 19, whichever is earlier (ACWDL 01-01; AB 2900)
417-12 Statutory provisions for CEC program (W&IC 14005.25(a))
417-13 Child's eligibility under CEC continues through guaranteed period, but may not follow another zero SOC continuous eligibility program (ACWDL 01-40)
417-14 CEC answers regarding MFBU composition, redeterminations, and SSI/SSP discontinuances (ACWDL 02-14)
417-14A Children who are eligible for CEC when added to an existing MFBU continue to retain $0 share of cost for initial 12-month period even if rest of MFBU has share of cost after annual redetermination (ACWDL 06-16)
417-14B Infant receiving benefits during continuous eligibility (deemed eligibility) remain eligible until one year old if DE requirements met (ACWDL 06-16)
417-16 "Bridging" program provides one month zero SOC to children losing full-scope, no-cost Medi-Cal and who are apparently eligible for Healthy Families (ACWDL 01-57)
418-1 County which accepts application, but is not county of responsibility, may still process application with consent of applicant, and initiate ICT (50135)
418-2 ICT rules (ACWDL 03-12)

420-1 Person must be citizen or eligible alien. Definition of eligible alien (50301(b))
420-2 Unnecessary to obtain MC 13 from self-declared U.S. Citizens or naturals (ACWDL 03-14)
420-3 Persons automatically U.S. Citizens or nationals if born in specified locations (ACWDL 03-14)
422-4 New conditions of eligibility of aliens for Medi-Cal benefits (W&IC 14007.5) [NOTE: Please select appropriate number(s)]
422-4A Certain aliens, otherwise ineligible for Medi-Cal, may be entitled to medically necessary pregnancy-related services, as of 7/22/99 (W&IC 14007.7)
422-7 Immigration/citizenship and SSN requirements (W&IC 14011.2; *Crespin* v *Coye*; ACWDL 96-34, 96-53)
422-8 Eligible alien immigrants eligible for Medi-Cal (ACWDL 93-14, 93-49)
423-2 California residence continues until residence in another state or country is established (50320(e))
423-3 California residency requirements effective 5/17/93 (50320(a))
423-3A Children's residence generally follows parents, with one exception (50320(c))
423-4 Verification and declarations required to establish residency (50320.1(a))
423-5 ALJ decides, based on preponderance of evidence, that California residency exists because of intent to remain indefinitely, or because of Medi-Cal regulations (50320.2(f))

423-6 Weighing California residency when there is evidence to the contrary that such residency exists (50320(f); ACWDL 96-27)

423-6A Border Crossing Card was conclusive evidence that person possessing such card is not a California resident for purposes of county determinations of Medi-Cal eligibility; counties must rescind prior discontinuances and provide retroactive benefits (ACWDL 95-47, 97-06, 98-48, 99-45; *Latino Coalition* v. *Belshé*)

423-6B Persons with B-1/B-2 visas were considered nonresidents of California for county purposes, counties must rescind prior denials/discontinuances and provide retroactive benefits (ACWDL 96-27, 97-06, 98-48, 99-45; modified by *Latino Coalition* v. *Belshé*)

423-6C State law requirements as how ALJs shall determine residency (W&IC 14007.1(b))

425-1 Persons in public institutions are ineligible for Medi-Cal; certain persons in jails or prisons, or minors in detention centers or correctional facilities, are specified as ineligible (50273(a)(1)-(a)(8))

425-2 Regulations make IMD residents between 21 and 65 ineligible for Medi-Cal (50273(a)(9))

425-2A Under state law, persons from 21-64 in IMDs are not eligible for Medi-Cal unless there is FFP (W&IC 14053)

425-2B State law allowed persons 21-64 in MDs to receive ancillary services, even without FFP until 7/1/01 (W&IC 14053.1, repealed 7/1/01)

425-3 Persons ineligible for Medi-Cal due to institutional status (set forth in 50273(a)) are ineligible only while actually in that status (50273(b))

430-1 Pregnant woman and postpartum eligibility (50260)

430-2 Eligibility to 200% program, pregnant women and infants (50262(a); ACWDL 94-91, 95-28, 95-52)

430-2A Period of eligibility and benefits available to pregnant women and infants in 185%, 200% programs (ACWDL 92-23; 50262(b), (c))

430-2B Retroactive eligibility under property waiver program (50262(b); ACWDL 95-28)

430-2C Income of parents living with pregnant minor is exempt for 200% disregard program purposes (ACWDL 03-34)

430-3 Children one to six years of age eligible if family income does not exceed 133% of federal poverty level, and such children are automatically property eligible (ACWDL 90-34, 98-06; 50262.5; W&IC 14148.75)

430-4 All FPL programs except QWDI shall disregard Title II COLAs until FPL charts are adjusted 4/1/01 (ACWDL 00-65)

430-5 In general, in Sneede situations, use net income of child plus parents to determine total income, and compare to MFBU standard, for percent program eligibility (MEPM 8G-6)

430-8 FPL for 2005 (ACWDL 05-13)

430-8A FPL insert for use in decisions (ACWDL ___)

430-9 EGHP and HIPP are considered nonhearable issues by CDHS (ACWDL 95-71 and 95-82)

430-10 Children six to 19 years of age eligible for zero SOC if family income does not exceed 100% of FPL and such children are automatically property eligible (ACWDL 92-23, 98-06; 50262.6; W&IC 14148.75)
430-10A Adults under 19 also covered under 100% program (ACWDL 98-16)
430-11 250% program for working disabled established effective 4/1/00 (ACWDL 99-67; AB 155)
430-11A Program description of the 250% WD program (MEPM 5R-1)
430-12 Beneficiaries of 250% program who don't pay monthly premiums may be discontinued (ACWDL 99-67)
430-12A Persons who do not pay premiums for two consecutive months will be discontinued from the 250% WD program for six months (MEPM 5R-1)
430-13 "Work" undefined in 250% program, but examples of "work" are given (ACWDL 00-51; MEPM 5R-2)
430-14 Allocations in the QMB, SLMB, QI, and 250% working disabled programs in 2002 and 2003 (ACWDL 01-66, 02-56)
430-15 MFBU composition in 250% WD program (MEPM 5R-1, 2)
430-16 Determination of net nonexempt income in 250% WD program (MEPM 5R-2, 3)
430-16A Net income limits, 250% WD program (MEPM 5R-3)
430-17 Net nonexempt property limits, 250% WD program (MEPM 5R-3)
430-18 Restricted service Medi-Cal recipients not eligible for 250% WD program (MEPM 5R-3, 4)
430-19 Premium payments for 250% WD program (MEPM 5R-5)
430-20 Person with earned income under 250% of FPL may qualify for Medi-Cal as disabled person even if income exceeds SGA limit (ACWDL 02-40)
430-25 Breast and Cervical Cancer Treatment Program authorized eff. 1/1/02, but no ACWDL nor Title 22 regulations issued as of 12/11/02 (W&IC 14007.71; H&S 104160-104163)
430-28 Safe Aims for Newborns eligibility (ACWDL 03-26; W&IC 14005.24)
431-1 MCCA, general instructions (ACWDL 90-01, 90-03)
431-2 Definitions, institutionalized and community spouse (42 USC 1396r-5(h); ACWDL 91-55)
431-3 Transfers, CSRA (42 USC 1396r-5(f); ACWDL 05-40)
431-4 MMMNA, basic plus adjustments for indexing, at state hearing (42 USC 1396r-5(d), (e), (g); ACWDL 05-40)
431-5 CSRA, adjustments to raise CSRA to provide for minimum income (42 USC 1396r-5(e)(2), (f)(2))
431-6 Deposits into joint account by LTC spouse treated as transfer of income to spouse at home (ACWDL 90-89)
431-7 Determination of income of institutionalized spouse (42 USC 1396r-5(d)(1))
431-8 State proposed regulations governing MCCA income, including exceptional circumstance rules and allocation to other family members (ACWDL 90-03, _____)
431-8A Family member maximum base allocation for current and prior year (ACWDL 05-20)

431-8B Allocation methodology for parent in LTC to children in home with no community spouse; or where person is in board and care or an MIA in LTC with spouse and/or children in home (ACWDL 90-03)
431-9 PACE participants entitled to spousal impoverishment treatment effective 7/1/97 (ACWDL 97-18)
431-9A Notice requirements to PACE participants; PACE participant may be living with community spouse (ACWDL 97-18)
432-1 QMB, general instructions; BDOA, income and resource limits (50258)
432-2 QMB, federal definition and state participation (42 USC 1396d-p; ACWDL 90-02, 91-09; MEPM 5F)
432-3 Payment of premiums, deductibles, and coinsurance for QMBs (W&IC 14005.11)
432-4 QMB requirements, including property and income limits (ACWDL 97-34)
433-1 SLMB eligibility criteria; period of eligibility; payment of Medicare Part B premiums (50258.1)
433-3 SLMB eligibility criteria and income forms reference (ACWDL 92-61; PL 101-508; 50258.1; MEPM 5J-1)
433-4 SLMB limitations in payment, eligibility criteria, and what Medicare Part B covers (MEPM 5J-1)
433-7 Two additional SLMB programs, for 120%-135%, and 135%-175%, provide for Medicare payments but no other Medi-Cal eligibility (ACWDL 97-45; PL 105-33)
434-1 TB program eligibility requirements (MEPM 5N; ACWDL 95-12, 95-39, 95-73, 98-02, 99-62; 01-03)
434-2 TB program net income determinations and exceptions (MEPM 5N; ACWDL 01-03, 01-66, 02-01)
434-3 TB program property determinations (MEPM, 5N, ACWDL 95-12, 95-39; 20 CFR 416.1207)
434-4 Coverage for TB eligible individuals limited to TB related services; no SOC for those services (MEPM 5N, ACWDL 95-12)
435-1 Definition of EPSDT supplemental services (51184(c))
435-2 Information to be included with EPSDT supplemental service request (51340(d))
435-3 EPSDT exceptions to general orthodontic coverage (51340.1(a)(2))
435-4 Background of EPSDT, medical necessity under EPSDT (ACL 00-83)
435-5 Required notification of EPSDT mental health services (*Emily Q.* v. *Bontá*; ACWDL 01-47)
436-1 Health care includes mental health services provided by county or city, Short-Doyle, Alcohol and Drug, in IMD, or for diagnostic, screening or remedial rehabilitative services (W&IC 14021)
436-2 Case management services are a benefit under the Short-Doyle Medi-Cal program (W&IC 14021.3)
436-3 Community health services defined, and covered by Medi-Cal when provided by Short-Doyle Medi-Cal (51341)
436-4 Short-Doyle coverage for substance abuse services (51341.1(a)-(d))

437-1 Establishment of QI program, and interim procedures; QI-2 program discontinued 12/31/02; QI-1 program discontinues 9/30/03 (ACWDL 97-45, 98-15, 98-47, 03-02, 03-20)
437-3 County duty to evaluate MN applicants for QMB, SLMB and QI, to see if state can be reimbursed for Part B Medicare premiums (ACWDL 99-61)
437-4 QI-1 program payments and eligibility criteria; program discontinued 9/30/03 (MEPM 5J-5; ACWDL 03-20)
437-4A QI-1 program sunset extended to September 30, 2007 (ACWDL 05-37)
438-1 General provisions governing the A&D FPL program (ACWDL 00-57, 00-68, 02-38)
438-2 Count parent's income in determining child's eligibility for A&D FPL program; if parent and child tentatively eligible, they are in separate units (ACWDL 01-18)
438-3 Statutory provisions for A&D FPL program (W&IC 14005.40)
438-4 IHSS payments are not allowable deductions for A&D FPL purposes (ACWDL 02-22, 02-22E; 50551.6, 50245)
438-4A MN deductions, other than IHSS, are allowable in A&D FPL (ACWDL 02-38)
438-5 Couples income standard can be no less than SSI/SSP couple payment standard (W&IC 14005.40(c)(1); ACWDL 02-24, 02-24E)
438-6 A&D FPL program is neither PA nor other PA (ACWDL 02-38)
438-7 Person cannot qualify for A&D FPL by paying Medicare Part B premium once state "buys in" (ACWDL 02-38)
438-8 One spouse can receive A&D FPL, while the other spouse receives MN benefits, or declines Medi-Cal (ACWDL 02-38)
439-1 CSRA amount past two years and current (ACWDL 03-54, 04-36, 05-40)
439-1A MMMNA amount past two years and current (ACWDL 03-54, 04-36, 05-40)
439-1B Insert CSRA/MMMNA amounts (ACWDL_____)
439-1C Family member base allocation amount last year and current (ACWDL 04-22, 05-20)
439-1D Insert family member base allocation amount (ACWDL _____)
439-2 Allocations in the QMB, SLMB, QI, and 250% working disabled programs in 2002 through 2005 (ACWDL 03-57, 04-39, 05-38)
439-3 Current and prior year TB income standard, resource limit, standard allocation and federal benefit rate (ACWDL 05-01, 06-01)
439-3A Insert for TB income standard, resource limit, standard allocation and federal benefit rate (ACWDL_____)
439-4 Current and prior two years Medicare Part B premiums (ACWDL 03-57, 04-39, 05-38)
439-4A Insert Medicare Part B premium (ACWDL_____)
439-5 Effective A&D FPL limit for individual and couples in current and prior year (ACWDL 05-15, 06-08)
439-5A Insert effective A&D FPL limit for individual and couples in 20__ (ACWDL ____)
439-6 SLMB income and resource limits (ACWDL 97-34, _____)
439-6A QMB income limit is 100% of FPL (ACWDL 97-34)

439-7 FPL, SLMB and QI levels effective April 2005 and April 2006 (ACWDL 05-12, 06-06)
439-7A Insert FPL (ACWDL _____)

440-1 SSI recipients are eligible, but their eligibility is determined by SSA (50179.7)
440-2 General description of Medi-Cal categories (50201)
440-2A Definition of "linked" (50055)
440-3 SSI and AFDC applicants not required to submit separate application. If AFDC or SSI is approved, Medi-Cal is automatic (50145)
440-3A When Medi-Cal eligibility is established for new members of the assistance unit. (All County Letter 03-18)
440-3B Effect of person moving into the home with income that causes assistance unit/household to be financially ineligible. New person ineligible for Medi-Cal. (All County Letter 03-18)
440-4 County must reevaluate eligibility under other Medi-Cal categories if eligibility ceases under one category; aid pending continues, effective 7/1/01 (50183(a); MEPM 4-0-3; W&IC 14005.31, .32, .37; ACWDL 02-59)
440-5 Basic Medi-Cal beginning date of aid rule (50193(c), replacing 50701(c), eff. 9/19/00)
440-6 Person is to be given option of Medi-Cal programs (50153(c))
440-7 Basis of AFDC deprivation (50205)
440-8 Parent may choose basis of deprivation under which he/she will receive linked AFDC-MN benefits (MEPM 5C-14)
441-1 Basic definition of "continued absence" (50213(c)(1))
441-2 Basic rules in joint custody situations (50374)
442-1 Definition of incapacity (50211)
443-1A U-parent deprivation can be established when the PWE is working under 100 hours in a month, or over 100 hours in the month but the family's net earned income does not exceed 100% of the FPL (AB 1107; MEPM §5C-13, 14)
443-2 Requirements under CDHS policy for U-deprivation (ACWDL 97-37; 50215; MEPM 5C-11, 12, 13, 14)
443-3 PWE is based on which parent had greater earnings in 24 months prior to determination of U eligibility; if equal earnings, parents may choose who is to be PWE (50215(c); MEPM 5C-11)
444-1 Medi-Cal eligibility for persons who meet 7/16/96 AFDC requirements, but U-deprivation requires only that PWE work fewer than 100 hours; effective 3/1/00, the PWE may work more than 100 hours if net earnings are at or below the FPL (ACWDL 98-43, 00-04; SSA 1931(b); PL 104-193; AB 1107; MEPM 5S-3(D.))
444-1A 1931(b)-Only Program--persons must first meet nonfinancial, then financial requirements (ACWDL 98-43; MEPM 5S-2)
444-1B Definition of applicant for 1931(b) purposes (ACWDL 98-43, Attachment 1)
444-1C Importance of determining 1931(b) eligibility to establish potential eligibility for TMC, because there are no time limits, because of AFDC type deductions, etc. (MEPM 5S-1)

444-1D Counties must certify they have completed a 1931(b) review by 5/1/01 (ACWDL 01-29)

444-1E 1931(b) person can choose aid under, e.g., Pickle or QMB, but not under optimal federal programs (MEPM 8G-4)

444-2 Age requirements for 1931(b) eligibility; child must be deprived and have 0 SOC for parent(s) to be eligible for 1931(b) (ACWDL 98-43; MEPM 5S-3, 4, 8G-2)

444-2A Example of how a parent can establish 1931(b) eligibility when the only child is eligible for a zero SOC under a percent program, here the 200% program (MEPM 8G-9)

444-3 Once U-deprivation is established, PWE can work more than 100 hours and not lose eligibility; applicants who work more than 100 hours can establish U eligibility if net earned income is under FPL (ACWDL 98-43; W&IC 14005.30; MEPM 5S-3)

444-4 MFBU is basic 1931(b) unit, but if there is an SOC and a *Sneede*/*Gamma* situation, modified *Sneede* rules must be followed to see if zero (0) SOC eligibility can be established for any MBU (ACWDL 98-43)

444-4A Persons ineligible for CalWORKs (e.g., fleeing felons, work sanctioned, aliens without SIS) may still be 1931(b) eligible (MEPM 8G-2, 5S-4)

444-4B Pregnant women in last trimester, without other children, may be 1931(b) eligible, but father of the unborn is not; if other deprived children are 1931(b) eligible, unborn may be used to increase family size from date pregnancy is established (MEPM 5S-3, 8G-2)

444-4C Stepparent may be aided as an essential person for 1931(b) purposes (MEPM 5S-4)

444-4D Parent, child, and caretaker relative of child can all receive 1931(b) benefits, but parent is financially responsible (MEPM 5S-4, 8D-3)

444-4E All persons in the family who are living in the home are included in the MFBU except those receiving cash benefits, e.g., SSI, CalWORKs, IHSS, and certain PA or other PA Persons (MEPM 8G-2)

444-4F Sanctioned WTW persons and CalWORKs Aus discontinued for failure to provide a monthly or annual income report are still 1931(b) eligible (ACWDL 02-59)

444-5 Income must be less than limit for family size; to determine income eligibility, use CalWORKs or AFDC rules as of 7/16/96, whichever is more liberal (ACWDL 98-43; MEPM 5S-5)

444-5A Determining net nonexempt income and income eligibility for the 1931(b) applicant or applicant family (ACWDL 98-43, Attachment I, 02-44)

444-5B Determining net nonexempt income and income eligibility for the 1931(b) recipient or recipient family (ACWDL 98-43, Attachment 1)

444-5C Rules for determining net income in 1931(b) cases are based on modified Title 22 regulations in draft form, new draft regulations, and Title 22 unmodified regulations, as amended by previous draft regulations (ACWDL 98-43, Attachment 1 and Exhibit B)

444-5D Applicants' net income limit for 1931(b) raised to FPL as of 3/1/00 100 hour PWE rule does not apply (ACWDL 00-04; MEPM 8G-1)

444-5E Status of income limits for the 1931(b) program as of 3/1/00 (ACWDL 00-48)
444-5F Social Security COLAs are not to be applied until new FPLs are issued (ACWDL 00-53)
444-5G 1931(b) income eligibility tests for applicants and recipients (MEPM 8G-5)
444-5H 1931(b) "Test A" income standards increase effective December 2004 (ACWDL 04-35)
444-6 Property is generally determined under FS rules for personal property and under 7/16/96 AFDC rules for real property, but exceptions exist in, e.g., automobile evaluation, and because certain Medi-Cal property rules and court cases are used in evaluating eligibility (ACWDL 98-43, Attachment 2)
444-6A Property limit for one in 1931(b) is $3000, and for two and more is MN limit (ACWDL 98-43; MEPM 5S-5)
444-6B Motor vehicles with equity value of $1500 or less are exempt in 1931(b) (ACWDL 01-62, eff. 6/1/01)
444-7 Procedure for evaluating Medi-Cal eligibility for a potential 1931(b) family (ACWDL 99-02E)
444-8B Partial list of personal property exemptions in 1931(b) (ACWDL 99-02E)
444-9 Time limits for counties to act in determining 1931(b) eligibility (MEPM 5S-2)
444-10 *Sneede* methodology in 1931(b) (MEPM 5S-6)
444-11 TMC eligibility in 1931(b) (MEPM 5S-7)
445-1 Disability may be verified in accordance with procedures established by DAPD, formerly DED (50167(a)(1)(D); ACWDL 97-54)
445-2 Disability may be verified through signed statement from SSA (50167(a)(1)(B))
445-3 If applicant does not have good reason for failing to attend consultative examination, he/she is subject to a determination of no disability (20 CFR 416.918)
445-4 SSI/SSP is a PA program, and retroactive coverage may be available for one year prior to request month (50148, 50078; ACWDL 95-81)
445-5 Presumptive disability criteria (MEPM 22C-3.6, revised 3/22/02)
445-5A SP-DAPD (formerly DED) can grant Presumptive Disability, but neither SP-DAPD nor county can grant retroactively; aid pending appropriate if timely filing (MEPM 22C-3.1, 3.2; ACWDL 97-54)
445-6 Disability determinations by other private or public groups not binding on SSA (POMS DI 24515.011)
445-9 County must refer disability application to DED within 10 days (ACWDL 93-50; *Radcliffe* v. *Cahill*)
445-10 Medi-Cal must continue for beneficiaries discontinued from Title II or SSI at least for 65 days, and if appeal is filed and is subject to federal review, until "FINAL" decision (i.e., no more appeals can be filed) is rendered (ACWDL 97-28)
445-12 No longer disabled SSI/SSP recipients to be treated akin to Edwards discontinuances (ACWDL 97-28)
445-13 SSI former recipients are PA recipients until appeal rights are terminated, even if they transfer to AFDC/TANF and then are discontinued from AFDC/TANF (ACWDL 97-28)
446-2 Eligibility requirements for RMA (50257)

446-3 Refugees entitled to Edwards benefits (ACWDL 97-57, 01-36, 01-39; *Edwards* v. *Kizer*; MEPM 24B-11)
446-3A Additional procedures for discontinuing refugee Medi-Cal when time limits have expired (ACWDL 98-36, 99-17; W&IC 14005.32, .37)
447-4 Pickle eligibility (Pickle Handbook, 15; *Lynch* v. *Rank*)
447-4A Actual receipt of SSI/SSP required, but only entitlement to RSDI required, for potential Pickle Eligibility (Pickle Handbook, 2)
447-5 Resource eligibility for Pickle persons (Pickle Handbook, 15)
447-6 Pickle person disregard multiplier (Pickle Handbook, 15; ACWDL 05-35)
447-7 Pickle income is established on a monthly basis (Pickle Handbook, 15)
447-8 Current year SSI/SSP payment standards (ACWDL 05-35)
447-8A SSI payment levels to determine if Pickle eligibility exists (ACWDL _____)
447-9 Method for computing Pickle income eligibility (Pickle Handbook, 18)
447-10 How to determine ISM from VTR or PMV (Pickle Handbook, 14, ACWDL 04-37, 05-35)
447-11 Disabled widow(er) eligibility under Pickle (Pickle Handbook §5-1 through-5-4)
447-14 DAC eligibility under Pickle (Pickle Handbook, 6)
448-1 IHSS recipients are eligible for Medi-Cal as long as net nonexempt income in excess of SSI/SSP level is applied to SOC (MPP 30-755.31; 50245)
448-2 Eligibility for Medi-Cal for severely impaired working individuals (Social Security Act, Title XVI, 1619(b); ACWDL 97-27)
448-4 Definition of MI persons under age 21 (50251(a))
448-5 Criteria for federal BCCTP (ACWDL 06-09)
448-5A Criteria for state-funded BCCTP (ACWDL 06-09)
448-5B Toll-free number for persons applying at county for, or apparently eligible for BCCTP (ACWDL 06-09)
449-1 Persons discontinued from SSI must reapply (50183, .5)
449-2 Requirements when SSI/SSP is discontinued (*Ramos* v. *Myers*; MEPM 5E)
449-3 SSI discontinued individuals receive continued benefits effective June 30, 2002, until CDHS issues new instructions; new instructions issued (ACWDL 02-45, 02-54, 03-24; *Craig* v. *Bontá*)
449-3A SB 87 procedures to be applied to Craig (discontinued SSI persons) beneficiaries (ACWDL 03-24)
449-3B Ongoing eligibility for persons discontinued from SSI/SSP until county completes eligibility redetermination (ACWDL 04-31)

450-1 How to treat persons under age 21, living away from their parent's home (MEPM 8C-1, 2, 3)
450-1A Definition of "child" (50030)
450-2 Current definition of "adult" (50014)
451-1 All family members living in the home shall be included in the MFBU (50373)
451-2 Definition of "family member" (50041)
451-3 Married couples living in the same home, even if legally separated, must be in the same MFBU (ACWDL 95-07; 50351, 50373)
452-1 Persons in LTC are in own MFBU; exceptions (50377(a); ACWDL 91-28)

452-2 Aged, blind, disabled person in LTC is usually in own MFBU (50377)
452-3 Definition of "Long-Term Care" (50056; W&IC 14050.3)
452-4 Certain inmates not eligible for Medi-Cal (ACWDL 93-42, 42 CFR 435.1009; 50273(a))
452-4A Persons in public institutions are ineligible for Medi-Cal; certain persons in jails or prisons, or minors in detention centers or correctional facilities, are specified as ineligible (50273(a)(1)-(a)(8))
452-4B Regulations make IMD residents between 21 and 65 ineligible for Medi-Cal (50273(a)(9))
452-4C Under state law, persons from 21-64 in IMDs are not eligible for Medi-Cal unless there is FFP (W&IC 14053)
452-5 Caretaker relative of FC child may receive Medi-Cal (ACWDL 95-07)
452-6 Unmarried father of unborn does not have to be in MFBU (ACWDL 95-07)
452-7 Noncaretaker relatives who are not parents may establish linkage to a child when the parent is absent from the home, but only one caretaker can be linked to each child; if independently linked, the caretaker may be in separate MFBU (MEPM 8D-3)
452-8 Child may be excluded, and eligibility and SOC and health care costs shall be determined based on remaining MFBU members (50381(a))
453-1 Determination of persons living in the home; temporary absence of child (50071; ACWDL 90-55)
454-1 Nonresponsible individuals may be in separate MFBUs (*Sneede* v. *Kizer*; ACWDL 90-76)
454-3 MBU's income compared to family size of MFBU in determining FPL eligibility (MEPM 8F-17, replacing ACWDL 92-09, 92-23)
454-4 Child's income for *Sneede* purposes includes child support payments, prorated unearned in-kind income, and interest income (ACWDL 92-09 replaced by MEPM 8F-10, 11))
454-5 Person with nonexempt income is *Sneede* person, even if there is no net income (ACWDL 92-09, replaced by MEPM 8F-13)
454-6 General rule regarding splitting into MBUs (ACWDL 92-09, replaced by MEPM 8F-3, 4)
454-6A MBU defined, and determination of SOC for the MBU (MEPM 8F-3, 6, 7, 8)
454-7 Equal allocation of income/property to spouse and child(ren) under *Sneede* (ACWDL 90-91) modified by *Gamma* to allow a parent a $600 income deduction (MEPM 8F-4)
454-8 *Sneede* procedures apply to property first, and then income; if property eligible, *Sneede* applies only to income *Sneede* proration rules modified by Gamma (ACWDL 90-91; MEPM 8F)
454-9 No allocation to unborn under *Sneede* (MEPM 8F-5, replacing ACWDL 90-91)
454-10 *Principé* property exemption can apply to MFBU or MBU at person's choice (97-41)
456-1 In *Sneede* situation, parent is allowed $600 to meet needs, and remainder of income is equally allocated to persons for whom parent is responsible (*Gamma* v. *Belshé*; ACWDL 96-29)

456-2 General rules for establishing MBUs, and requirement to apply *Sneede* if financial ineligibility or SOC in nonresponsible relative situation (MEPM 8F-1, 2)
456-3 MBU defined, and determination of SOC for the MBU (MEPM 8F-3, 6, 7, 8)
456-4 MBUs which are property ineligible may not be used to establish AFDC-MN linkage, but property ineigibility is not established until a child is determined ineligible for a percent program (MEPM 8F-5)
456-7 "Name on the check" creates presumption of ownership, but if benefits are on behalf of designated persons, those persons are owners of income (MEPM 8F-10)

461-1 Net income from property (50508(a))
461-2 Unearned income examples (50507(a))
461-2A SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé*)
461-2B SDI verification required (ACWDL 96-09)
461-3 Title IV and BIA assistance is exempt for income and property purposes (ACWDL 94-06; PL 102-325; 20 USC 1087uu)
461-4 Determinations of August 11, 1993 and following for value of annuities, payments from annuities, and county duty to advise applicant/beneficiary when annuity is improperly annuitized, after having considered whether restructuring annuity will cause undue hardship (MEPM 9J-13, 14)
462-1 Earnings includes wages, salaries, bonuses, commissions, tips, self-employment (50503(a))
462-2 SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé*)
462-2A SDI verification required (ACWDL 96-09)
462-3 TWC is earned income for AFDC-MN and MI (ACWDL 95-63; *Sawyer* v. *Belshé*)
463-1 Determination of net profit from self-employment (50505)
463-2 Factors to be considered in determining whether a person is an employee, or self-employed (MEPM 10M-1, 2)
463-3 Allowable and nonallowable self-employment deductions (MEPM 10M-2; 50505)
464-1 Treatment of fluctuating income (50518)
464-2 Conversion of weekly or biweekly income to monthly income (50517)
465-1 Responsible relatives are spouse for spouse and parent for child (50351(a))
465-2 Income and resources of parents living with child to be used; also income of absent parent if parent claims child as dependent for tax purposes (50351)
466-1 Only available income shall be used in determining a person's or family's SOC (50513(a), 50515(a))
466-2 Unavailable income includes deductions from benefit payments for purposes of collecting overpayments (ACWDL 92-39)
466-3 MN person in board and care has unavailable income if income is paid to facility for care and support, and exceeds maintenance need level; after 4/1/00

there is a $315 deduction allowable (50515(a)(3); *Pettit* v. *Bontá*; ACWDL 00-56)

466-3A Persons living in licensed board and care facility, even if facility is characterized as an assisted living arrangement, receives income exclusion (50515(a)(3); ACWDL 99-31)

466-4 "Name on the check" creates presumption of ownership, but if benefits are on behalf of designated persons, those persons are owners of income (MEPM 8F-10)

467-1 Income in kind is only for housing, utilities, food, and clothing, and only is income if entire item of need is provided (50509)

468-1 $90 deduction from earned income (AFDC/MN/MI persons) (50553.1)

468-2 Deduction from earned income for child care or incapacitated person expenses (50553.5)

468-3 Deduction of court ordered alimony or child support (50554)

468-4 Dependent care deduction from earned income, $30 plus 1/3 deduction from earned income; deductions no longer available as of 5/1/98 (50553.3; AB 1542)

468-5 To determine AFDC-MN income, deduct amounts appropriate under State AFDC plan (42 CFR 435.831(b)(2))

468-6 SDI is earned income for AFDC-MN and MI (ACWDL 96-09; *Tinoco* v. *Belshé*)

468-7 TWC is earned income for AFDC-MN and MI (ACWDL 95-63; *Sawyer* v. *Belshé*)

469-1 $20 deduction from unearned income of ABD-MN persons or their spouse or parent; unused portion is subtracted from earnings (50549.2)

469-2 Reduction for court-ordered child support or alimony for ABD recipients (*Gibbins* v. *Rank*; ACWDL 87-77; 50554)

469-3 To determine ABD income, deduct amounts as appropriate under SSI, plus optimal state supplemental plan amounts (42 CFR 435.831(b)(3))

469-4 $65 (plus any unused portion of the $20 deduction) plus 1/2 earnings deduction for ABD persons, and spouses or parents of those persons (50551.3)

469-5 Additional actual work expenses allowed for blind earners (50551.4)

470-1 General reference to deductions and exemptions (50519)

470-4 Medical insurance deduction (50555.2)

470-5 Exemption of payments made from California Victims of Crimes (50534, 50448)

470-6 AAP exempt income; AAP recipient not in MFBU with other household members (ACWDL 92-83)

470-7 Quarterly interest payments are excluded up to $60 as irregular unearned income (ACWDL 92-37; 50542)

470-8 Exemption of interest and dividend income for purposes of determining income eligibility for some SSI/SSP based Medi-Cal programs (ACWDL 05-17)

480-1 Conversion of property in itself has no effect on eligibility (50407)

481-1 Eligibility exists if property limit is met at any time during month (50420(c))

481-2 Property limit for one is $2,000 (50420)

481-3 Property limit for different MFBUs (50420)
481-5 California cannot use lower resource standard than used under cash assistance program (42 CFR 435.840)
481-6 Spenddown of excess property to establish eligibility after month in which excess property precluded eligibility (ACWDL 97-41; *Principe* v. *Belshé*)
481-6A Example of establishing eligibility for Medi-Cal after being over the property limit for the entire month by spending down on qualified medical expenses (ACWDL 97-41)
481-7 QMB, TB, Pickle and 250% working disabled programs use SSI resource rules, which limit resources to $2000 for one person and $3000 for individual and spouse (ACWDL 99-67; 20 CFR 415.1205(c))
482-1 Owner of property is generally person with legal title (50404)
482-1A Property held in name of person may not be available in certain circumstances (ACWDL 90-01)
482-2 Resources of married individual in SNF are separate property and community property share at time of admission (W&IC 14006.2(c))
483-1 Separate property and share of community property of any person in MFBU shall be considered in determining eligibility (50403)
483-2 Applicants shall be informed that they may establish eligibility by bringing property within limit during month and must be given MC 007; same rule applies to those who inquire about Medi-Cal (91-78, 98-07, 00-11)
483-2A Requirement to give applicant information about spenddown following *Principe*, whether or not there appears to be excess property (ACWDL 97-41)
483-2B Requirement to give all LTC applicants 10-point type forms explaining property transfers (ACWDL 00-11; W&IC 14006.3, .4)
483-3A Treatment of certain MQTs and SLDs as available property prior to 1/28/98 (ACWDL 93-07; 50489-50489.9)
483-3B Rules regarding MQTs and SLDs established 8/11/93 or after (42 USC 1396p(c), (d); ACWDL 94-01; 50489)
483-4 Unavailable property not considered in determining eligibility (50402, ACWDL 90-01)
483-4A Evidentiary requirements when property is in applicant's or beneficiary's name and it is claimed that the property belongs to another (ACWDL 90-01)
483-5 Property unavailable when individual is unconscious, comatose, or incompetent at any time during the month (ACWDL 97-41)
483-5A Property of incompetent individual considered available if another individual can get access to the property (ACWDL 94-62)
483-6 Loans which require repayment included in property reserve; other loans, income, then property (50483)
483-7 Definition for purposes of trusts, annuities, SLDs (50489(b)(1)-(b)(12))
483-8 Trusts are MQTs, OBRA 93 or others (50489(c))
483-9 Verification of written and oral trusts; no oral trust for real property (50489(e))
483-10 Before denying eligibility based on OBRA 93 trust or annuity, county must notify claimant it will consider, and must actually consider, whether undue hardship exists (50489.5(h))

483-11 Determinations of August 11, 1993 and following for value of annuities, payments from annuities, and county duty to advise applicant/beneficiary when annuity is improperly annuitized, after having considered whether restructuring annuity will cause undue hardship (MEPM 9J-13, 14)
483-12 Reasons funds in IRA may be unavailable (ACWDL 02-51)
484-1 Mortgages, deeds of trust, and notes are to be included in the property reserve; which mortgages are classified as real property (50441)
484-2 Net market value of property is owner's equity minus encumbrances (50415)
484-3 Stocks, bonds, mutual funds to be included; method of valuation (50456)
484-4 Life estate interest in real or personal property, valuation (50442)
484-5 Valuation of personal property under Code (W&IC 14006(g))
484-6 Value of property holdings determined as of date of application (W&IC 14006(h), (i))
485-1 Motor vehicles--exemption; determination of value, nonexempt vehicles (50461; ACWDL 96-55)
486-1 Income received and deposited in an account during a month is not property in that month (50453(a)(1); ACWDL 91-28)
486-2 Exclusion of certain business property (50485, ACWDL 91-28)
486-2A Clarification of treatment of business property (ACWDL 91-28, 95-22)
486-2B "Necessary for employment" defined; examples of exempt business property (ACWDL 91-28)
486-3 Life insurance policies--when exempt (50475)
486-4 Mobile homes--real property v. personal property (50463(a))
486-5 Entire amount in savings or checking to which applicant has unrestricted access is included property unless clear evidence establishes otherwise (50453)
486-5A Modification to availability of checking and savings accounts (ACWDL 90-01, 91-28; 50453)
486-6 Six-month exemption of retroactive SSI and Title II benefits (50455(b))
486-7 Exemption of recreational items (50469)
486-8 Property purchased or sold under contract of sale; determination of ownership and income (50405)
486-9A Burial fund cannot be commingled and cannot be undesignated without losing its exemption (50479(b); ACWDL 92-58)
486-9B Exempt burial funds (50479(a))
486-10 Exemption of burial trusts, federal requirements (20 CFR 416.1231(b), 42 CFR 435.845(d))
486-11 Title IV and BIA assistance is exempt for income and property purposes (ACWDL 94-06; PL 102-325; 20 USC 1087uu)
487-1 Transfers of property more than two years prior to initial application presumed nondisqualifying; applies only to certain institutionalized persons (50408, 50409; 42 USC 1396p(c), W&IC 14002, 14006; ACWDL 90-01)
487-1A Policy in treatment of nonexempt property on or after 1/1/90 (ACWDL 90-01; 42 USC 1396p, 1396r-5)
487-2 Transfer of exempt property does not result in ineligibility; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006; 50408(a); ACWDL 90-01)

487-2A Policy as to which transfers of property on or after 1/1/90 do not affect eligibility (ACWDL 90-01; 42 USC 1396a, 1396p, 1396r-5)
487-3 No disqualifying transfer if adequate consideration received; definition of adequate consideration; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006, 50408(a)(3), (a)(6); ACWDL 90-01)
487-4 Transfer of property not disqualifying when adequate consideration is received, or when no intent to establish eligibility or reduce SOC; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006, 50409(b); Beltran v. Myers; ACWDL 90-01)
487-5 Period of ineligibility after transfer of property to qualify for aid; how computed; applies only to certain individuals (50411; ACWDL 90-01; 42 USC 1396p(c))
487-6 Restricted benefits for disqualifying transfers of property for LTC patients (ACWDL 92-57)
487-6A 2005 and 2006 Statewide APPR for Medi-Cal transfer of property period of ineligibility (ACWDLs 05-09, 06-11)
487-6B Statewide APPR for Medi-Cal transfer of property period of ineligibility (ACWDL ____)

490-1 Definition of real property (50074)
490-2 Lien procedure for property formerly a home when person is in long-term care (50428)
492-2C Requirement to give applicants notice that a home can be transferred for less than FMV (ACWDL 02-60; W&IC 14006.7)
492-3 Utilization requirement generally (50416)
492-3A Modifications to utilization requirements (ACWDL 91-28, 90-01; 50416)
492-5A Treatment of certain MQTs and SLDs as available property prior to 1/28/98 (ACWDL 93-07; 50489-50489.9)
492-5B Rules regarding MQTs and SLDs established 8/11/93 or after (42 USC 1396p(c), (d); ACWDL 94-01; 50489)
492-6 $6,000 other real property exemption (50427)
492-7 Unavailable property not considered in determining eligibility (50402, ACWDL 90-01)
494-1 Net market value of property is owner's equity minus encumbrances (50415)
494-2 Life estate interest in real or personal property, valuation (50442)
494-3 Determination of market value of real property (50412)
495-2 Exclusion of certain business property (50485, ACWDL 91-28)
495-2A Clarification of treatment of business property (ACWDL 91-28, 95-22)
495-3 Situations where property no longer used as a home remains exempt as a principal residence (50425(c))
495-3A Subjective intent to return home is sufficient to establish that home is exempt property (ACWDL 95-48; 50425(c))
495-3B Home can be real or personal property, fixed or mobile, on land or water (50044)

495-4 Value of property holdings determined as of date of application (W&IC 14006(h), (i))
496-1 Transfers of property more than two years prior to initial application presumed nondisqualifying; applies only to certain institutionalized persons (50408, 50409; 42 USC 1396p(c), W&IC 14002, 14006; ACWDL 90-01)
496-1A Policy in treatment of nonexempt property on or after 1/1/90 (ACWDL 90-01; 42 USC 1396p, 1396r-5)
496-2 Transfer of exempt property does not result in ineligibility; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006; 50408(a); ACWDL 90-01)
496-2A Policy as to which transfers of property on or after 1/1/90 do not affect eligibility (ACWDL 90-01; 42 USC 1396a, 1396p, 1396r-5)
496-3 No disqualifying transfer if adequate consideration received; definition of adequate consideration; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006, 50408(a)(3), (a)(6); ACWDL 90-01)
496-4 Transfer of property not disqualifying when adequate consideration is received, or when no intent to establish eligibility or reduce SOC; applies only to certain institutionalized persons (42 USC 1396p(c), W&IC 14002, 14006, 50409(b); Beltran v. Myers; ACWDL 90-01)
496-5 Period of ineligibility after transfer of property to qualify for aid; how computed; applies only to certain individuals (50411; ACWDL 90-01; 42 USC 1396p(c))
496-6 Restricted benefits for disqualifying transfers of property for LTC patients (ACWDL 92-57)

502-1 Amount of maintenance need effective (50603, ACWDL 95-19) [NOTE: Please submit worksheet]
502-2 Maintenance Need (Long-Term Care) (50605(a))
502-3 Persons entitled to upkeep allowance; calculation of upkeep allowance (50605(b))
502-4 Computation of SOC; general (50653(a))
502-5 Prescribed drug or service, not covered by Medi-Cal, may be applied to SOC (ACWDL 89-54; Johnson v. Rank)
504-1 County duty to retroactively revise SOC when change resulting in a decrease in SOC is reported in timely manner; option of adjustment or corrected MC 177S (50653.3(a))
504-1A BIC cards have replaced MC 177 forms and Medi-Cal cards in all counties as of 6/1/97 (Denti-Cal Bulletin Vol. 13, No. 13 (6/97); 50653.3, 50657; ACWDL 96-06)
504-2 When Medi-Cal applicant incurs medical costs while application is pending, and benefits are later approved, DHS must reimburse beneficiary for out-of-pocket costs (*Conlan* v. *Bontá*)
505-1 Three-month retroactive eligibility (50197(a), replacing 50710(a), eff. 9/19/00)
505-1A Basic Medi-Cal beginning date of aid rule (50193(c), replacing 50701(c), eff. 9/19/00)

505-2 Three-month retroactive coverage, limitations (50197(a)(3), replacing 50710(a)(3), eff. 9/19/00)
505-3 Retroactive coverage, when application must be made (50148)
505-4 Determining income in retroactive months (ACWDL 02-43)
506-4 General rules on *Hunt* v. *Kizer* (MEPM 10R-1)
506-5 Definitions for Hunt purposes (MEPM 10R-1 through 4)
506-6 Applying old medical bills for Hunt purposes (MEPM 10R-4, 5)
506-7 Criteria for applying current and old medical bills under Hunt (MEPM 10R-5, 6)
506-8 Verification requirement under Hunt (MEPM 10R-6, 7)
506-12 Principe spenddown of excess property cannot be used to meet SOC, or for Hunt purposes (ACWDL 97-41)

511-1A When potential overpayment occurs; no potential overpayment if beneficiary/representative reports within competence, or fails to perform an act which is a condition of eligibility due to CDHS or county error (50781)
511-1B Potential overpayment occurs when the beneficiary fails to report other health coverage, and the beneficiary receives double reimbursement or CDHS has to pay for the services (50781.5)
511-2 Determination of potential overpayment and referral to CDHS (50783)
512-2 Computation of Medi-Cal overpayment; overpayment due to incorrect SOC computation (50786(a)(2)(B))
512-3 Computation of excess property overpayment (50786(a)(2)(A))
512-3A *Principe* v. *Belshé* does not modify overpayment rules for beneficiaries who have failed to report property holdings (ACWDL 97-41)
512-4 State law provides that, in situations when beneficiary reported within competence, there is no liability for any overpayment (W&IC 14009(d))
512-5 Managed care capitation rates are treated as a covered service when computing the Medi-Cal overpayment (ACWDL 01-38)
513-1 Repayment demand may be made against beneficiary or financially responsible person (50787(c))
514-1 Right to demand repayment of Medi-Cal overpayments; notice required; suspension if hearing requested (50787(a), (b))

520-1 Medi-Cal card shall be proof of authorization for covered services (50733(a))
521-1 Conditions under which county can issue current or past Medi-Cal cards (50743)
522-1 Replacement of Medi-Cal card, limitations (50746(a))
522-2 Examples of county administrative error when Medi-Cal card is requested more than one year after service (MEPM 14E-1; ACWDL 94-77; 50746)
522-3 After NOA denying Medi-Cal eligibility due to excess property, applicant may still establish eligibility up to three years later, and county must rescind and issue benefits including NOA if necessary (ACWDL 97-41)

522-4 Issuance of replacement Medi-Cal card more than one year after month of service due to extenuating circumstances (MEPM 14E-2, 3)
523-1 Authority for CDHS to impose restrictions for improper utilization of Medi-Cal services; time of restriction (50793(a), (d))
523-2 Restrictions are temporarily suspended if hearing is requested (50793(f), (g))
523-3 General rule is limit on prescribed drugs to six per month unless there is prior authorization (W&IC 14133.22)
526-2 SOC met when provider certifies payment for services to be made by patient (50657(a)(6))
526-3 Retroactive adjustment of SOC when eligibility for deduction is determined at later date (MEPM 12C)
526-4 *Principe* spenddown of excess property cannot be used to meet SOC, or for *Hunt* purposes (ACWDL 97-41)
526-4A BIC cards have replaced MC 177 forms and Medi-Cal cards in all counties as of 6/1/97 (Denti-Cal Bulletin Vol. 13, No. 13 (6/97); 50653.3, 50657; ACWDL 96-06)
527-1 When Medi-Cal applicant incurs medical costs while application is pending, and benefits are later approved, DHS must reimburse beneficiary for out-of-pocket costs (*Conlan* v. *Bontá*)

530-1 Medical justification must exist to show that requested services are necessary to protect life or prevent significant disability in reviewing TARs (W&IC 14133.3, 51303)
530-2 Retroactive approval of authorization requests when recipient has not identified self as a Medi-Cal recipient (51003(b)(4))
530-3 Definition of "prior authorization" (51003(a))
530-4 Use of Manual of Criteria for Medi-Cal Authorization for medically necessary procedures (51003(e))
530-5 Prior authorization--lowest cost item or source (51003(f))
530-6 Experimental services--no coverage (51303(g))
530-7 Beneficiary must use other health care coverage before using Medi-Cal (51005(a))
530-8 TAR must be approved or denied within average of five working days (W&IC §14133.9)
531-1 Circumstances under which full dentures are a covered benefit (51307(e)(7))
531-1A Rule on balance of removable partial denture (Denti-Cal Provider Manual 4-32; Denti-Cal Bulletin, Vol. 8, No. 9 (7/92))
531-1B Five year limitation on prosthetic appliances (Denti-Cal Provider Manual 4-32)
531-1C When prosthetic appliance can be authorized more than once in five-year period (Denti-Cal Provider Manual 4-32, 33)
531-1D Stayplates not authorized to replace posterior teeth only (Denti-Cal Provider Manual 4-34)
531-2 Medically necessary dental services must be authorized if covered by statute, even if fiscally expensive, as long as no cheaper alternative procedures are available (W&IC 14132(h); Jackson v. Stockdale; 51307(d)(4) and (d)(5))

531-3 Circumstances under which laboratory crowns are covered as program benefit (51307(e)(6))
531-3A Provider Manual criteria for restorative dentistry and crowns (Denti-Cal Provider Manual 4-28, 30)
531-3B Posterior crowns for adults only a benefit when used as abutment for a fixed partial denture or removable partial with cast clasps and rests. (Denti-Cal Bulletin Volume 19, Number 23)
531-4 Covered benefits--vital pulpotomy, dental caries (51307(b)(7), (8))
531-5 Partial dental prostheses only a covered benefit when necessary for balance of complete artificial denture (51307(d)(4))
531-6 Denti-Cal criteria for periodontal services (Denti-Cal Provider Manual 4-23)
531-7 List of services not covered by Denti-Cal (51307(d))
531-8 Certain endodontic benefits are covered (51307(e)(5))
531-9 Statutory limitations on Denti-Cal benefits as of 8/15/93 (W&IC 14132(h))
531-10 W&IC 14132(h) enjoined 12/17/93. (*Clark* v. *Belshé*)
531-11 Orthodontic requirements for handicapping malocclusion (Denti-Cal Provider Manual 4-44)
531-11A Information to be included with EPSDT supplemental service request (51340(d))
531-11B EPSDT exceptions to general orthodontic coverage (51340.1(a)(2))
531-11C Denti-Cal has implemented guidelines to standardize the use of the HLD Index in the orthodontic program (Denti-Cal Bulletin, Vol. 13, No. 8 (5/97))
531-11D Handicapping malocclusion rules apply to cleft palate deformities when care is under CCS or when documented and necessary under the dental services program (Denti-Cal Provider Manual 4-44)
531-11E Description of covered and non-covered orthodontic benefits in the Denti-Cal program (Denti-Cal Provider Manual 5-77)
531-11F Orthodontic services under the CCS program (Denti-Cal Provider Manual 5-87, removed eff. 8/02)
531-11G Information to be included in EPSDT dental TAR; guidelines as to which claims will be approved (Denti-Cal Provider Manual 5-83, 84, 85, removed eff. 8/02)
531-11H Maxillofacial services covered subject to prior authorization (Denti-Cal Provider Manual 4-37, 38)
531-12 Old rule: Dental coverage under the CHDP program (Denti-Cal Provider Manual 5-90)
532-1 Definition of durable medical equipment (51160)
532-2 Durable medical equipment, general (51321)
532-3 Prosthetic and orthotic appliances--when covered, monetary limits (51315(a))
532-4 CDHS cannot exclude stairway chairlifts as durable medical equipment when that would be inconsistent with statute (W&IC 14132(m); 51160(e)(11); *Blue* v. *Bontá*)
533-1 Medical transportation services require prior authorization except in emergency (51151, 51323(b))
533-2 Wheelchair van services authorizable if person's medical and physical condition meets criteria (51323(a)(3))

533-3 Nonemergency medical transportation requires description of medical reason necessary, by professional (Manual of Criteria 12.1.2)
533-4 Examples of when a wheelchair van may be authorizable (Manual of Criteria 12.1.4.)
533-5 Contraindication examples to the use of private or public transportation (Manual of Criteria 12.1.4-12.1.5)
533-6 Federal regulations require states to ensure necessary transportation to and from providers (42 CFR 431.53)
534-1 Emergency services--exemptions from prior authorization; special rule for aliens (51056(a)-(c); W&IC 14007.5(d))
534-2 Emergency medical services under federal law defined; do not include organ transplants (42 USC 1396b(v))
534-3 Elimination of state-only funded nonemergency pregnancy-related services for aliens not lawfully present in the U.S. (ACWDL 97-22, 98-12)
535-1 General rule is limit on prescribed drugs to six per month unless there is prior authorization (W&IC 14133.22)
535-2 Beneficiary can request a hearing regarding deletion of a drug, and receive ongoing treatment (W&IC 14105.405(a), (b))
535-3 Drugs covered by Medi-Cal (51313(a) and (c)(1))
535-3A Authorization for unlabeled use of drugs not granted unless unlabeled use is reasonable and current practice (51313(c)(4))
536-1 Provision of physical therapy is covered if beneficiary will improve significantly in reasonable time (51309(d)(2)(C))
536-2 Physical therapy limited to prevent hospitalization or continued treatment after discharge from hospital (51309(b))
536-3 Psychiatric services require prior authorization and treatment plan except in emergency (51305(d))
536-3A Prior authorization defined in Mental Health (51003(a); 9 CCR 1810.234)
536-4 Health care includes mental health services provided by county or city, Short-Doyle, Alcohol and Drug, in IMD, or for diagnostic, screening or remedial rehabilitative services (W&IC 14021)
536-4A Mental health services defined (9 CCR 1810.227)
536-4B Specialty mental health services defined (9 CCR 1810.247)
536-5 Mental health providers not responsible for providing certain services, which may be covered by a managed care plan, a larger service package, or Medi-Cal (9 CCR 1810.355(a), (b))
536-6 Duty of MHP to refer beneficiary for appropriate treatment when MHP does not provide coverage (9 CCR 1810.415(d))
536-8 Medical necessity criteria to be eligible for mental health services from the MHP (9 CCR 1830.205; W&IC 14680)
536-8A State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))
536-9 Criteria for authorizing out-of-plan services when a beneficiary is participating in an MHP (9 CCR 1830.220)

536-10 Rights of beneficiary to choose a provider when the beneficiary is in an MHP (9 CCR 1830.225)
536-11 When NOAs must be issued by the MHP (9 CCR 1850.210(a), (b), (c))
536-11A When NOAs must be issued by the MHP because medical necessity criteria allegedly not met (9 CCR 1850.210(i))
536-11B Contents of the MHP NOA issued under 9 CCR 1850.210(a), (b), or (c) (9 CCR 1850.210(d))
536-11C When an NOA must be sent in regard to "medical services" (51014.1(a))
536-11D Contents of the required NOA for reduction or termination of "medical services" (51014.1(c), (i))
536-11E APP requirements when there is a timely filing after proposed reduction or termination of "medical services" (51014.2(a), (b))
536-11F Effective 07/01/05, beneficiaries must exhaust problem resolution process before filing for state hearing (DMH 05-03)
536-11G Effective 07/01/05, MHPs must issue aid pending when applicable (DMH 05-03)
536-12 APP for specialty mental health sources (9 CCR 1850.215)
536-15 Case management services are a benefit under the Short-Doyle Medi-Cal program (W&IC 14021.3)
536-16 Community health services defined, and covered by Medi-Cal when provided by Short-Doyle Medi-Cal (51341)
536-17 Short-Doyle coverage for substance abuse services (51341.1(a)-(d))
537-1 Requests for acute continuing care services, general requirements (51003(c)(2))
537-2 Criteria for acute care psychiatric services (Manual of Criteria 5.2.1)
537-3 Psychiatric hospitalization guidelines (Psychiatric Hospitalization Guidelines, 1)
537-4 Definition of acute in-patient hospital service (W&IC 14105.98(a)(17))
538-1 Hearing aids--when covered (51319(a), (b), (f))
538-2 Hearing aids--replacement (51319(g))
538-3 Podiatry services--when covered (51310)
538-4 Definition of adult day health care; definition of elderly person (54013; H&S 1570.7(c))
538-5 Persons potentially eligible for adult day health services (54201)
538-6 Requirements for participation in adult day health care include a physician's written request, a multidisciplinary team assessment, and the participant's agreement (54203)
538-7 Requirements for a written request for adult day health services from the physician (54205)
538-8 Requirements for prior authorization in the adult day health services program (54209)
538-10 Definition of EPSDT screening sources (51184(a))
538-11 Definition of EPSDT diagnosis and treatment services (51184(b))
538-12 Definition of EPSDT supplemental services and examples of measures covered (51184(c), (d), (g), (j))
538-13 Information to be included with EPSDT supplemental service request (51340(d))

538-14 Pediatric day health care EPSDT defined; respite care excluded as a benefit (51184(l); 51340.1(s); W&IC 14132.10(a))
539-1 TARs--when aid pending appropriate (*Frank* v. *Kizer*)
539-2 NOA to Medi-Cal recipient required when TAR has been submitted and denied or modified (ACWDL 86-8; *Jackson* v. *Rank*)

540-1 Out-of-state medical care; exemption for emergency services (51006(a), (b))
540-2 Statutory criteria for out-of-state care (W&IC 14022)
541-1 Provider cannot bill beneficiary after acceptance as Medi-Cal patient (W&IC 14019.4; 51002(a))
541-2 Provider billing requirements, authority for late payment of bills (51008, .5)
541-3 When Medi-Cal applicant incurs medical costs while application is pending, and benefits are later approved, DHS must reimburse beneficiary for out-of-pocket costs (*Conlan* v. *Bontá*)
542-1 Provider grievance procedures (51015)
543-1 Right to state hearings for Medi-Cal beneficiaries denied, involuntarily discharged, or provided reduced substance abuse services (50951, 51341(p))
543-2 Right to pretermination hearings for narcotic treatment applicants and beneficiaries under Title 9 (9 CCR 10010, 10170(a) and (b)(5), and 10420)
543-3 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))

550-1 Level of care; criteria for skilled nursing care (51335(j)) [NOTE: Please specify appropriate number(s)]
550-3 Level of care; definition of skilled nursing care (51124(b))
550-4 Level of care; criteria for intermediate care (51334(l)) [NOTE: Please specify appropriate number(s)]
550-5 Level of care; definition of intermediate care (51120(a))
550-6 Level of care; definition of "out-of-home" care facility (MPP 46-140.1)
555-1 CMSP coverage excludes mental health, alcohol, and drug abuse services (W&IC 16801)
555-2 CMSP limited to certain named or contracting counties (W&IC 16809)
555-4 CMSP excludes sealants and orthodontics, but includes other services provided primarily to children (Denti-Cal Provider Manual 5-95)

560-1 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))
561-1A Requirements needed to be eligible for PCSP (51181, 51183, 51350 MPP 30-780.4)
561-2 PCSP only for those who would be unable to remain safely at "home"; "home" defined (51350(b), 51145.1)

561-2A Home can be real or personal property, fixed or mobile, on land or water (50044)
561-2B State law authorizes PCSP for persons living in their homes and other authorized locations (W&IC 14132.95(a)(1))
561-3 Personal care services prescribed by a physician; physician defined (51350(c); MPP Handbook 30-780.2(e); ACL 93-67, 94-93)
561-4 Failure to cooperate means ineligibility for PCSP and IHSS (ACL 93-67, 94-07)
561-5 All Medi-Cal eligibility determinations including those for PCSP recipients must follow Medi-Cal rules (ACWDL 04-27)
561-5A Medi-Cal eligibility determinations on PCSP and IHSS Plus Waiver cases done by Medi-Cal workers following Medi-Cal rules (ACWDL 05-21)
561-6 CDSS position is that IHSS recipient, who receives personal care services, and is an eligible recipient must sign a form SOC 426. Failure to sign the form results in loss of personal care and ancillary services (ACWDL 99-13, 99-25; 30-757.1; W&IC 12300(f), 14132.95)
561-6A State law and regulations do not permit person eligible for personal care services under PCSP to receive IHSS for those services (30-757.1; W&IC 12300(f), 14132.95; ACL 99-25)
561-7 CDSS policy, regarding noncompliance to respond to notice to submit SOC 426, is to send additional notice before discontinuing (ACL 99-25)
562-1 Provider shall not be beneficiary's spouse; provider shall not be parent of a beneficiary who is a minor child (51181; 50014; 50030 Handbook 30-767.3)
562-2 Providers must be approved by CDHS and sign required forms (51483.1, 51204)
562-3 Beneficiaries or their representatives can choose provider (51483.1, 51204(a); MPP Handbook 30-767.4)
562-4 Contract agency providers selected per W&IC 12302.1 (51204(b); MPP Handbook 30-767.4(b))
562-5 Personal care provider can appeal to county, then to court (51015.2; W&IC 14104.5; MPP Handbook 30-767.5)
563-1 PCSP includes personal care and ancillary services; services covered by PCSP (51183; MPP Handbook 30-780.1)
563-1A Protective supervision and Domestic and Related-Only services are PCSP funded (ACL 05-05)
563-2 Needs assessment governed by MPP, Uniform Assessment Tool (51350(a); MPP Handbook 30-780.2(a))
563-3 Services limited to 283 hours monthly; no dollar limit (51350(b); MPP Handbook 30-780.2(b); ACL 95-42)
563-3A Nonseverely impaired PCSP recipient who also receives protective services may receive up to 195 hours of protective supervision and additional PCSP, not to exceed 283 hours per month (ACL 93-30; W&IC 12300(g)(2), 12303.4, 14132.95)
563-3B In PCSP, no NSI/SI distinction; all cases eligible to 283 hour maximum although if case meets NSI criteria, only 195 hours may be for protective supervision (ACIN I-28-06)

563-4 Grooming excludes cutting with scissors or clipping toenails (51350(f); MPP Handbook 30-780.2(f))
563-5 Menstrual care for application of sanitary napkins and cleaning (51350(g); MPP Handbook 30-780.2(g))
563-6 Paramedical services, specific inclusions (51350(g), (h); MPP Handbook 30-780.2(g), (h))
563-7 Range of motion exercises--limitations (51350(h)(2); MPP Handbook 30-780.2(h)(2))
563-8 Regional centers cannot be considered an alternative resource (ACL 98-53; *Arp* v. *Anderson*)
564-1 PCSP for eligible Medi-Cal beneficiaries is governed by W&IC, CCR, and operated pursuant to MPP (W&IC 14132.95; MPP 30-700.2)
564-2 Prior to 08/01/04, PCSP funding for eligible recipients except IHSS funding for restaurant meal allowance and protective supervision IHSS Plus Waiver effective 08/01/04 (MPP 30-700.3; ACL 93-21, 93-30, 05-05)
564-3 Statutory requirement that IHSS/PCSP recipient must live in his/her home or abode of choice (W&IC 12300(a))
564-4 Home can be real or personal property, fixed or mobile, on land or water (50044)
564-5 Income eligible former IHSS recipients will not be penalized due to potential higher SOC (ACWDL 99-13; AB 2779)
564-5A IHSS and PCSP eligibility determinations made following Medi-Cal rules (ACWDL 04-27)
564-5B PCSP and IHSS Plus Waiver share of cost computed using Medi-Cal rules, but recipient pays only balance of Medi-Cal share of cost if IHSS share of cost is less than Medi-Cal share of cost (ACL 05-05)
566-2 Specific Medi-Cal explanations for evaluating personal care services (51183(a))
566-3 Specific Medi-Cal explanations for evaluating ancillary services (51183(b))
567-1 Intent of legislature to seek federal approval of Medicaid waiver known as IHSS plus waiver (W&IC 14132.951(a))
567-2 To extent feasible, IHSS plus waiver incorporates IHSS eligibility requirements (W&IC 14132.951(b))
567-3 To the extent FFP available, IHSS program benefits furnished as Medi-Cal benefits through IHSS plus waiver (W&IC 14132.951(c) and (d))
567-3A Services authorized under IHSS Plus Waiver administered under IHSS rules (W&IC 14132.951(e))
567-4 DHS may implement IHSS plus waiver through ACWDL or similar publication for up to 18 months (W&IC 14132.951(h))
567-5 If conflict exists between terms of IHSS plus waiver and ACWDL, regulations or similar publication, terms of waiver controls (W&IC 14132.951(i))
567-6 IHSS and PCSP eligibility determinations made following Medi-Cal rules (ACWDL 04-27)
567-6A Medi-Cal eligibility determinations on PCSP and IHSS Plus Waiver cases done by Medi-Cal workers following Medi-Cal rules (ACWDL 05-21)
567-7 IHSS Plus Waiver recipients (ACL 05-05; ACWDL 05-21)

567-8 PCSP and IHSS Plus Waiver share of cost computed using Medi-Cal rules, but recipient pays only balance of Medi-Cal share of cost if IHSS share of cost is less than Medi-Cal share of cost (ACL 05-05; 05-05 errata)
567-9 Exemptions under the IHSS Plus Waiver program (ACWDL 05-29)
567-10 A parent working less than full time may be paid as a provider under IPW; two parents working full time may not be paid providers under IPW (ACIN I-28-06)
567-11 ID waiver recipients who meet IPW criteria are eligible for the IPW; parents of minors who receive Medi-Cal under ID waiver may provide services under IPW (ACIN I-28-06)
567-12 Respite care is offered under IPW (ACIN I-28-06)
567-13 Under IHSS Plus Waiver, NSI recipients have 195 hour maximum, SI recipients have 283 hour maximum (ACIN I-28-06)
570-1 Overview of the Medi-Cal waiver process (MEPM 19D-2, 3)
570-2 Six types of Medi-Cal waivers (MEPM 19D-3)
570-3 NOA required for applicants (MEPM 19D-10)
570-4 Effective date of Medi-Cal coverage when waiver has special eligibility rules (MEPM 19D-10)
570-5 Waiver persons may request IHSS, or PCSP (MEPM 19D-11)
570-6 MFBU rules for waiver persons (MEPM 19D-11)
571-1 Description of the DSS Home and Community-Based Services Waiver (MEPM 19D-4)
571-2 Eligibility requirements for DDS Home and Community-Based Services Waiver (MEPM 19D-4)
572-1 Description of the IHO waivers (MEPM 19D-6)
572-2 IHO is referring agency in Model NF waiver (MEPM 19D-6)
572-3 Eligibility requirements for Model NF waiver (MEPM 19D-6, 7, 8)
573-1 Description, eligibility for Nursing Facility Level of Care waiver (MEPM 19D-8, 9)
574-1 Description, eligibility for AIDS waiver (MEPM 19D-9)
575-1 Description, referring agency, eligibility for IHMC waiver (MEPM 19D-8)
576-1 Purpose of MSSP is to serve elderly, frail individuals who are certifiable for placement in nursing facility (W&IC 9560(a); 42 USC 1396n(c))
576-1A MSSP program eligibility requirements and goals (ACWDL 03-22)
576-2 Services provided under MSSP (W&IC 9561)
576-3 MSSP waiver allows MSSP to grant hours above statutory IHSS maxima if maxima has been reached, and to exclude MSSP as an alternative resource when maxima IHSS not authorized (W&IC 9562(b); ACL 00-34)
576-4 Description of MSSP waiver (MEPM 19D-9)
576-5 Eligibility, aid codes for MSSP (MEPM 19D-10)
576-6 California Dept. of Aging has inter-agency agreement with CDHS to review and monitor MSSP (MEPM 19D-10)
576-7 MSSP eligibility determination (ACWDL 03-22)

580-1 State must specify a single State agency to administer Medicaid program, and that agency must not delegate to others outside agency authority to exercise

administrative discretion, or issue policies, rules, and regulations on program matters (42 CFR 431.10(b), (c))

581-1 Definition of PHP "contract" (53108)

581-2 Definition of "disenrollment" from PHP (53114)

581-3 Generally, membership in PHP continues indefinitely after enrollment (53426)

581-4 Disenrollment for loss of eligibility, for good cause, or at beneficiary request (53260(a), W&IC 14412(a))

583-1 Medi-Cal beneficiaries may have to participate in managed care plan to receive Medi-Cal services (W&IC 14131.15)

584-1 Mandatory GMC enrollees (53906(a))

584-2 Duty to mail an enrollment form to eligible GMC beneficiaries; if beneficiary does not enroll within 30 days, the beneficiary may be assigned to a GMC plan (53921(c), (d))

584-3 Duty to provide information to GMC beneficiary of, e.g., processing time, alternative to GMC, restrictions on disenrollment from 2nd to 6th month of enrollment (53926.5(a))

584-4 Duty to provide information to GMC beneficiary of, e.g., available services, address and phone number of primary care provider, appropriate disenrollment form (53926.5(b))

584-5 GMC beneficiary must enroll in dental and PHP or PCCM plan (53921(e))

584-6 Assignment of GMC beneficiary to plan when person does not choose a plan within 30 days, or disenrolls and does not select a new plan (53921.5(a))

584-7 Primary health care services are to be within 10 miles of GMC beneficiary's residence (53922.5(a))

584-8 Disenrollment of beneficiary from GMC when person is an Indian, or has a complex medical condition (53923.5)

584-9 Duty to assign a primary care provider, criteria to be used to assign, and opportunity for beneficiary to change (53925)

585-1 Counties which are in Two-Plan Model Managed Care, and basic services provisions (53800(a), 53840(a))

585-2 Mandatory enrollment in Two-Plan Model (53845)

585-2A Duty of mail information to beneficiary; beneficiary is assigned a plan if no exemption form is submitted within 30 days (53882(c), (d))

585-2B Assignment of beneficiary to plan when no choice is made (53883(a), (b))

585-2C Health Care Options must consider the beneficiary's language needs, if known, in assigning the beneficiary to a plan (53884(b)(3))

585-3 Voluntary enrollment in Two-Plan Model (53845(b))

585-4A Criteria for receiving fee-for-service when a beneficiary would otherwise be in a Two-Plan Model (53887(a), eff. 12/19/00)

585-4B No exemption granted for complex medical condition in certain instances, e.g., having been a plan member for 90 days (53887(a)(2)(B), eff. 12/19/00)

585-6 Obligations to make enrollment/disenrollment form available (53888)

585-7 Preference for placing family members in same plan (53884(b)(4))

585-8 Travel time to primary health provider should not exceed 30 minutes or ten miles, unless waived by beneficiary (53885)

585-9 Beneficiaries may continue in fee-for-service, after receiving exemptions, for limited period (53887(a)(3), (4))
585-10 Request for exemption from plan enrollment must be on HCO Form 7101 or 7102 (53887(b), eff. 12/19/00)
585-11 Time limits for processing enrollment and disenrollment requests (53889(e), (f), (g), eff. 12/19/00)
585-12 CCS services for children in managed care are billed on a fee-for-service basis (W&IC 14094.3)
585-13 Definition of CCS services (Health and Safety Code 123840)
585-14 Managed care plan must provide Medi-Cal covered services unless excluded under contract (53851)